Transforming the PMHS in an Era of Health Reform

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Message from a Fortune Cookie:

"May you live in interesting times...."

An Analogy:

Implementing major system change in government is like changing a flat tire—while the car is racing downhill

Patient Protection and Affordable Care Act

- Signed into law on March 23, 2010
- Acronym for new law is either "ACA" or "PPACA"
- Provisions of new law are phased in from signing date through end of decade
- Many major changes take effect in 2014 or later (e.g., expanded Medicaid eligibility)

Some Basic Problems Meant to be Addressed by ACA

- Discriminatory insurance industry practices that deny coverage to people who are ill
- Lack of affordable insurance coverage for people of limited means & for small employers
- Limited Medicaid eligibility for non-aged adults
- Poor access to health care for people without insurance coverage ("the uninsured")

Key Features of ACA

- Expands Medicaid—primarily for childless adults < 65
- Subsidizes private health insurance for low- and moderate-income households not eligible for Medicaid
- Prohibits numerous discriminatory practices in private insurance (such as denial of coverage to people with pre-existing conditions)
- Mandates coverage by large employers
- Subsidizes coverage by small employers

Effective in 2010

- March 23
  - States must maintain current Medicaid & CHIP (Children's Health Insurance Program) eligibility levels & enrollment practices
  - Small employers get tax credits covering 35% of premium costs (50% in 2014)
- June 24
  - Temporary high risk pools established for qualified uninsured people with pre-existing conditions (of particular interest to people with chronic mental illness)

Effective September 23, 2010
(as new health plan year begins)

- Children cannot be denied coverage because of pre-existing conditions
- Prohibits insurance plans from:
  - Imposing lifetime dollar caps on coverage
  - Rescinding coverage when an insured person gets ill
- Plans must offer coverage to children of insured parents up to age 26 (had been up to 25 in MD)

Effective 2014

- Expanded Medicaid eligibility with 100% federal funding for new eligibles added by ACA
- Mandated coverage by large employers (with >50 workers)
- Individual Mandate (all U.S. citizens & legal residents must obtain coverage with some limited exceptions)
- Health Benefit Exchanges begin to function
- Annual dollar insurance coverage limits are prohibited

New Health Insurance Exchanges

- Will be operational by 2014 at state or regional level, replacing temporary high risk pool coverage
- Will function as "patient friendly" marketplaces where individuals & small employers can purchase health insurance at affordable prices based on clear, understandable terms of coverage & assurances of quality care
- Primary target populations include people who lack affordable employment-based coverage
- Should be of particular benefit to those with pre-existing conditions/chronic illnesses

Exchanges & Other Coverage

- Exchanges will help make coverage "seamless" with Medicaid, CHIP
- Ideally, Exchanges will help determine which type of coverage is optimal for each household member
- "No Wrong Door" for access to Exchanges, Medicaid, CHIP coverage

ACA: Changes to Delivery System

- Increases financial aid to medical students opting for Primary Care
- Raises Medicaid primary physician payment rates to Medicare levels at no cost to states
- Increases funding for federal safety net providers (Community Health Centers & National Health Service Corps) by $11 billion over 5 years, almost doubling their capacity
- New program will support School-Based Health Centers (including behavioral health services)

Navigating the Maze

- Establishes & funds new system of "Navigators" to assist in obtaining insurance coverage and negotiating health care delivery system
- Establishes "Health Home" option under Medicaid
  - An enhanced case management/care coordination model for individuals with chronic illnesses, including serious mental illness
  - Similar to Wrap-Around & System of Care models
  - Will oversee care for people using multiple providers
- New Accountable Care Organizations (ACOs) will offer range of services within a single group of providers & hold group accountable for outcomes

Integrated Care for Co-Occurring Illnesses

- ACA recognizes importance of treating "whole patient," integrating service delivery
- Funds training & demonstration projects to integrate substance abuse & mental health services
- Also funds training & demos to integrate behavioral health & somatic/physical medicine
- Authorizes $50 million in grants to support co-location of primary and specialty care (including psychiatry)

Impact on Uninsurance

- ACA will ultimately reduce total uninsured by a projected 32 million Americans
- 16 million new eligibles will be enrolled in Medicaid
- SAMHSA estimates that as many as one-third of newly insured will need behavioral health services
- Will boost health insurance coverage from 83% to 94% of non-aged U.S. legal residents by 2019
- An estimated 23 million will remain uninsured, including 7 million undocumented immigrants

Uninsurance among Children

- Almost two-thirds of uninsured children were eligible for Medicaid or CHIP but were not enrolled (2007)
  - ACA helps to simplify & encourage enrollment
- Conversely, 32% of all children were covered by Medicaid or CHIP—major factors in assuring coverage & reducing uninsurance
- Two-thirds of middle class families with access to employer-based coverage report their children remained uninsured because they could not afford their share of health plan costs

Impact of ACA on Maryland

- Estimated 400,000 previously uninsured Marylanders will get coverage as a result of new law
- State's historic concerns and investment in health care offer a good platform on which to implement health reform
- Governor O'Malley convened a Maryland Health Care Reform Coordinating Council to help oversee & plan state response to ACA

Maryland Medicaid/CHIP by the Numbers

- ACA will raise Medicaid eligibility to 133% of Federal Poverty Level (FPL) in 2014
  - Principal beneficiaries will be childless low-income adults
  - Likely to have higher relative impact in other states, especially in South and West
  - Maryland Primary Adult Care (PAC) program already pegged to 116% of FPL
  - Maryland Child Health Program (MCHP) already sets eligibility at 300% of FPL

Enhanced Federal Support for New Medicaid Eligibles

- Federal match rate for new Medicaid eligibles will be 100% from 2014-2016
  - Offers states an incentive to enroll new eligibles—at no expense to states
  - States may raise Medicaid eligibility before 2014, but 100% rate for new eligibles only available in 2014
  - Match rate is scaled down to 90% in 2020

Impact on Children & Families in Maryland

- Beginning in 2014, ACA offers subsidized, affordable coverage thru Exchanges for people with household income between 133% and 400% of FPL
  - 400% for family of four = $88,200 annual income
- In Maryland, this means:
  - Children between 300% of FPL (MCHP limit) and 400% get access to new subsidized, affordable coverage via Exchanges
  - Non-aged adults (including parents) get access to subsidized, affordable coverage from 133% to 400% of FPL
- ACA also allows former foster children to retain Medicaid eligibility thru age 26, especially important for transition-aged youth

Impact on Minorities in Maryland

- DHMH estimates that 62% of Maryland's uninsured are racial and/or ethnic minorities (Office of Minority Health & Health Disparities)
- This underscores the importance of offering culturally & linguistic competent care to those who will be newly insured thru the ACA

ACA and CHIP/MCHP

- Extends federal authorization for CHIP thru 2015—reducing uncertainty about its future
- Beginning in 2015, states will receive 23% increase in federal CHIP matching rate (up to limit of 100%) for all CHIP enrollees
  - In Maryland, rate will increase from 65% to 88%
  - Relieves states with lowest median income from all CHIP costs

Uninsurance: Major Obstacle to MH Access

- Lack of insurance coverage is the single largest obstacle to obtaining mental health treatment and supportive services
  - 87% of Americans who do not seek needed MH services cite lack of insurance coverage as top reason (2004 survey)
  - 44% of Americans do not have mental health coverage (or are unsure if they do) (2008)
  - Many of the uninsured with MH needs must rely on the Public MH System (PMHS)

Uninsurance among People with Mental Illness

- According to SAMHSA estimates
  - Uninsurance among people with SMI = 20.4%
  - For people with other mental disorders, uninsurance = 18.2%
  - Uninsurance among people with no mental disorder = 11.4%
- Almost by definition, serious mental illness is a pre-existing condition, limiting access to insurance prior to enactment of ACA

Children's Access to MH Services

- Significant numbers of children and youth in need of mental health services do not receive them
- One recent study (2002) found that 75-80% of children & youth do not receive needed mental health services
- This seems to represent a substantial reservoir of unmet demand, since it is estimated that 10% of children have a diagnosable MH disorder and 20% have a significant MH impairment

A Surge in Use of MH Services?

- On average, people who are uninsured use only 60% of the health care resources used by people with insurance
- Depending on extent of pent-up demand for MH services, expanded coverage may pose major challenge to both public & private MH delivery systems
- Workforce constraints/shortages of professionals may exacerbate problem

An Increase in Early Intervention & Prevention?

- Expanded coverage may lead to a reduction in both monetary & personal costs, such as:
  - Reduced demand for crisis services
  - Lessened Emergency Room overcrowding (despite evidence from Massachusetts)
  - Reduced involvement with the criminal justice system

Primary Care & MH

- Primary care practitioners are likely to play larger role in diagnosing & treating mental illness—or in referring to MH specialists
  - Increases importance of integrating care
  - Increased access to primary care is expected to reduce higher incidence of co-occurring physical illness among people with MH disorders

The Primary Care-MH Link

- Primary Care sector functions as "de facto MH service system" for many Americans
- Primary Care is now the sole form of health care used by over 1/3 of patients with a mental disorder using health care
- Primary Care Physicians (PCPs) prescribe 41% of antidepressants, some without adequate knowledge base
- Fewer than 1/3 of PCPs routinely screen patients for mental illness

Overall Impact on the PMHS

- Over long run, pressures on the PMHS as a safety net provider & payor of last resort will likely decrease
- Expanded coverage under ACA is likely to lead to influx of more federal funding into behavioral health services, primarily because of Medicaid expansion

Special ACA Provisions for MH

- Creates National Center of Excellence for Depression to fund research into effective treatment of Depression & Bipolar Disorder
- Authorizes funding for research into & education about Post-Partum Depression
- Removes restrictions on Medicaid coverage for smoking cessation drugs, barbiturates, benzodiazepines

Parity of MH Coverage

- Parity of coverage means limitations on MH benefits cannot be more restrictive than those on other insurance coverage (for physical illness)
- ACA builds on expanded federal parity legislation enacted in recent years
- Insurance available through Exchanges must:
  - Cover MH & substance abuse services
  - Provide MH & substance abuse benefits at parity with other coverage

Controversial ACA Provisions

- **Individual Mandate:** By 2014, with limited exceptions, all Americans must obtain health insurance or pay penalty
- **Tax on "Cadillac" Health Plans:** In 2018, imposes tax on premiums paid for broader, more expensive coverage
- **Employer Mandate:** Requires employers of >50 employees to offer health insurance coverage or pay a penalty

An Uncertain Future

- Constitutional Challenge: 21 state attorneys general have filed suit against ACA, alleging that it is unconstitutional
- Public Opinion: recent polls indicate many Americans oppose ACA
- Congressional Repeal: will change in majority party in 2011 lead to repeal or major modifications of ACA?

Some General Concerns

- ACA is complicated & very confusing
  - Even "experts" do not fully understand ACA & all its implications
  - Public education about new law is imperative, especially for vulnerable groups like MH consumers
- Expanded coverage will not automatically lead to expanded access to health or MH services
  - Reasons for concern about adequacy of provider networks in face of increased demand for care

Challenges for PMHS

- Is there ***capacity*** to provide MH & substance abuse services (workforce)?
- Have strategies been developed to improve ***infrastructure*** (data, health IT, electronic health records)?
- How can we facilitate ***linkages*** with primary care & other providers?
- How will essential ***non-medical services*** (e.g., housing, employment) be funded?

Unintended Consequences

- A law this complex is bound to lead to unintended consequences.
- The likelihood of unintended consequences reinforces the need for vigilance and careful monitoring of implementation, especially in the short run.

Summing Up: A Beneficial Intervention to Fix a Broken Health Care/MH Delivery System

- Despite concerns about impact of ACA, it will expand coverage & reduce uninsurance
- It will reduce uncertainty about coverage for current & future illnesses, reducing personal stress
- It will increase access to MH treatment & services
- Children & families in MD will benefit primarily from private insurance reforms & Exchanges
- Medicaid will play expanded role for covering non-aged adults (< 65)

Into the Mainstream

"The policy challenge is to encourage the integration of people with mental illness into the mainstream…at the same time recognizing unique features of their circumstances that…social and medical insurance programs must take into account to effectively serve them."

Richard Frank & Sherry Glied: *Better But Not Well*

Some Health Reform Resources

- General Federal website: http://www.healthcare.gov/
- SAMHSA: http://www.samhsa.gov/healthreform/
- Maryland Health Care Reform Coordinating Council: www.healthreformmaryland.gov
- Kaiser Family Foundation: http://healthreform.kff.org/
- Families USA: http://www.familiesusa.org/health-reform-central/
- Health Reform GPS (Robert Wood Johnson Foundation/GWU): http://www.healthreformgps.org/?cid=xem-emc-ca